Health Information Technology Policy Committee
Final
Summary of the March 7, 2012, Meeting

KEY TOPICS

1. Call to Order

Mary Jo Deering, Office of the National Coordinator (ONC), welcomed participants to the 33rd meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee meeting being conducted with the opportunity for public comment, and that a transcript would be made available on the ONC Web site. She conducted roll call, and then turned the meeting over to Farzad Mostashari, National Coordinator for Health Information Technology.

2. Remarks – Farzad Mostashari, National Coordinator

Mostashari discussed a study recently in the news that found that doctors who order a lot of imaging tests are more likely to have systems that let them view images. The study found an association between ordering more tests and having systems that allow for viewing those tests, which is not surprising. What was surprising, however, were the authors' suggestions that the federal government's ongoing multi-billion dollar HIT efforts may not yield the anticipated cost savings because of duplicative tests and that in fact, computers may drive costs up, not down. Mostashari clarified that this study was not about electronic health records (EHRs), much less about the meaningful use of EHRs. It was about electronic viewing of imaging results. When the authors considered EHRs, they found that their use showed no associations with tests ordered. Also, he pointed out, the study used 2008 data, and much has changed since then.

As an epidemiologist, Mostashari said, it was remarkable to him to see the classical fallacy with association and causality. It could be that ordering more tests leads to buying imagery systems, not the other way around. Also, this study used data from the National Ambulatory Medical Care Survey, which was not designed to answer any questions about costs, nor was it designed to look at the association between EHRs and quality. From a clinical and patient point of view, it did not answer the appropriateness of test ordering.

Health information technology (HIT) serving as the foundation for reducing health care costs and increasing quality and safety will not come about by people ordering more or fewer lab tests. The big savings happens in the coordination of care, and in reducing harmful complications and hospitalizations. Providers who are embracing new delivery and payment systems, such as accountable care organizations, know full well that success is not possible without a foundation of HIT. HIT is a tool, a power to effectively improve quality and reduce costs.

Mostashari explained that he is struck by how much learning there is yet to be done on making meaningful use of even some of the simplest requirements. Collecting and managing a problem list is one example. In one community of informatics specialists, some have been reporting using the problem list as a foundational aspect of communication between each other and with the patient. Other hospitals and providers, who have quite advanced systems, simply check the appropriate box on the problem list. Maintaining an active problem list was not something they did other than to quality for meaningful use incentive patients. Mostashari expressed frustration at some EHR systems that have their usual way of collecting smoking status, and a way for the provider to set it up however they want, and then a separate form to open up to collect smoking status the meaningful use way.

3. Review of the Agenda

HITPC Chair Paul Tang thanked Mostashari and seconded his sentiments. He reviewed the agenda, noting that the Committee would spend the morning on meaningful use updates within the context of the Notice of Proposed Rulemaking (NPRM; published that morning in the Federal Register) and from the perspective of the Centers for Medicare and Medicaid Services (CMS). The afternoon sessions would focus on consumer attitudes towards EHRs and an update on health information exchange.

4. Update on Meaningful Use NPRM

Paul Tagalicod of CMS thanked the Committee for its work, saying that probably nobody knows better than this group how much effort went into publishing the NPRM on meaningful use stage 2. CMS relied very heavily on HITPC recommendations as well as public feedback from stakeholders received through this committee. With this proposed rule, they are taking a big step forward, beyond basic data collection and into a future of more robust information exchange. There are some new ideas and objectives that encourage exchange of information between not only providers, but networks, organizations, and technologies. CMS is looking toward a health care system that is infused with information critical to providing the best possible care for patients. This information will not be anchored to a particular organization, but can be shared, and can follow the patient instead of just the provider. The objectives include providing for online access to download information, so that patients can take an active part in health care.

On the provider side, the NPRM proposes some critical alignments with quality measurements. They are aligning quality sets in various CMS improvement programs, and aligning how that information is collected, so that those participating in multiple CMS programs can report the same measure once and not have to submit multiple measures for multiple programs. Tagalicod believes they are proposing for stage 2 something that moves them toward the end goal of improving quality of care and outcomes, and reducing the costs of health care. These goals will not be realized at once, and even stage 2 will not bring about an immediate change—it does, however, lay the foundation for the kind of infrastructure that will help to achieve these goals.

Tagalicod explained that meaningful use is not about providing information that people do not want, or recording random data, but rather what is important and relevant to a patient’s ongoing care. They do not want people to print out office visit summaries just because they have to for meaningful use, but they want the information given out to be useful, relevant, and helpful. The CMS recognizes that meaningful use has to give doctors, nurses, and hospitals the freedom to do what they do best: provide the best care for their patients.

Objectives and thresholds are not meant to be the entire framework for patient care, but a starting point that providers can use. He hopes that providers will think about the spirit in which those objectives were proposed. The CMS tried to make this proposed rule reflect everyone’s feedback and experience, because they believe the goals of improving care and reducing costs will only be achieved when everyone works together. He asked that the group look at the proposed rule and provide comments about what could be clearer or could be done better, and also to comment on what works and what was done well.

CMS's Robert Anthony walked the group through an extensive set of slides showing the changes and the highlights of the proposed rule. The official comment period began that morning, and will last through May 6. The easiest way to offer comments is to submit them through www.regulations.gov, although CMS can also accept other formats. The proposed rule covers the following:

- Minor changes to stage 1 of meaningful use
- Stage 2 of meaningful use
- New clinical quality measures
- New clinical quality measure reporting mechanisms
- Appeals
- Details on the Medicare payment adjustments
- Minor Medicare Advantage program changes
- Minor Medicaid program changes.

The goal is to release the final rule in the summer of 2012, probably late summer. He discussed the timeline for stage 2, saying that the earliest possible implementations will start at FY14 (which is October 1, 2013), or calendar year 2014 for eligible professionals (EPs).

Anthony discussed the core menu structure, which maintains roughly the same number of objectives as stage 1, with some stage 1 objectives combined and some being eliminated. He reviewed the core and menu objectives for both EPs and hospitals, using a series of slides that shows what is new, what is changed, and what has stayed the same as compared to stage 1.

Changes were made to some stage 1 objectives in this proposed rule, based on what they have seen so far and feedback from vendors and providers. Changes address confusion around computerized physician order entry (CPOE) and the test of HIE. There were also changes regarding e-copy and online access of healthcare information, and public health objectives. These will be added to, except where prohibited by local or state guidelines.

Anthony reviewed some of the clinical quality measures (CQM), and then discussed CQM reporting for EPs and hospitals in 2013, and 2014 and beyond. He discussed payment adjustments, showing an outline for how adjustments will be applied, and reviewed the hardship exceptions. Then, he covered some Medicaid-specific changes, including a correction that was made to allow inclusion of children's hospitals that do not have a CMS Certification Number.

Discussion

Marc Probst referred back to the *New York Times* article that Mostashari referred to at the beginning of the meeting. Probst said that the last two lines of the article quoted a doctor who, when questioned as to whether or not he would continue to use an electronic medical record, said he would never go back. The proposed rule is excellent work, and he is concerned about two parts. First, he is worried that people trying to get on the "escalator" might be making suboptimal decisions about vendors. He felt that the criteria were looking good, and that this was more of a timing issue. His second concern is at the other end of the escalator, as people are getting off. This is making people incredibly dependent on electronic technologies. The discussion is about safety, privacy, and a lot of these things, but the basic infrastructure components have to be there to sustain this model. There are significant safety issues if they are not in place.

Deven McGraw noted that much of the content of the proposed rule has considerable implications for technology, and not just in the areas of privacy and security. It would be helpful to hear more about what is in the certification rules, as those linkages are critical.

Larry Wolf agreed with the unanimous support so far. He suggested that the arrow graphic that has been used to describe stages 1 through 3 should be updated. It includes sharing of data in the first stage, but sharing really did not occur in stage , so he suggested moving sharing to stage 2. He liked the continued presence of some flexibility. However, given the way things are regrouped, this flexibility adds some complexity. He reinforced the importance of alignment with other programs. He also said that one of the reasons there was such slow adoption in the first year of meaningful use is that it was just physically impossible to get it rolled out. The year that is built in now is still a very, very tight timeframe. They need to look back more deeply on what has been learned, problem lists being one example.

Neil Calman suggested that the idea of pulling out the problem list, medication list, and allergy list and just making it a requirement at transition is a bad signal. It is in the use of those lists in day-to-day practice that they actually become useful. Moving them to a place where they become fields in a transition document weakens their strength. He also said that the proliferation of quality measures is becoming more of a certification issue than an actual meaningful use issue. People can generate all these quality measures, but that does not mean the information will actually be used. How they are reflected in the EHR, and how people are able to access and update them, is part of the meaningful use component. The other piece seems to be part of certification.

Calman added that there are places where the field is still very dependent on what is available on the receiving side, as in public health. He expressed a wish that they could have done more than just the immunization piece to signal that this needs to get moving. Syndromic surveillance is important, although finding incentives to leverage it (i.e., dollars) is a significant challenge.

Christine Bechtel is glad that they are asking for comment about which measures would be good around the Physician Quality Reporting System (PQRS). She referred to measures that are not meaningful, or not appropriate with HIT use. It is important not just to look at higher value measures in this context, but also to make sure the concepts are appropriately stratified. Bechtel also noted that the Quality Measures Workgroup led a series of tiger teams that recommended measure concepts for stages 2 and 3, and the ONC made some investments to advance those concepts for stage 2. She asked, are there building blocks in the proposed rule that can be built on, or how will those things come together? Mostashari said there will be a briefing on the status of those items. They took many of those recommended as core measures and are attempting new measures to fill those gap areas. There are, in the current NPRM, measures listed as being in development that they hope to have completed shortly after the final rule comes out. They are seeking comment on those newer measures that are under development and being built so as to be HIT sensitive, and looking for insights into which measures are most sensitive.

Bechtel asked what the implication would then be for PQRS, where those measures are not a part of it. ONC's Patrick Conway explained that PQRS is on an annual rulemaking cycle, so they would be able to update it to ensure alignment. From a principle standpoint, they have been aligning but also prioritizing measures. A subset of PQRM measures could be useful for meaningful use. Comments in this area were encouraged.

Joe Francis noted some concerns about the fact that meaningful use requires interaction with, knowledge of and support on computers. Does the rule speak to the use of scribes? This opens up a series of interesting professional issues. Anthony commented that nothing in the stage 2 NPRM addresses scribes. In general, they are trying not to prescribe workflow, and outside of CPOE, there is nothing in the NPRM about how that information gets into the system—just that it is recorded. Obviously, CPOE is different: if there are clinical indications or alerts, then somebody with some clinical knowledge will need to be able to take some action on that. With regard to other objectives, he thinks a scribe could easily fit into that workflow.

One participant said it was impressive to see how many of the lessons of stage 1 have been factored in here, and he urged that they remain vigilant that the burden of the requirements are sustainable, and commensurate with the value of the improvements in care that they seek. There are smarter ways to achieve the 10% of external transitions of care being required to cross both product and cross provider. Instead of that approach, which has serious downsides, in order to ensure that EHRs are interoperable he recommended creating some federal reference points: a provider could make sure they can connect to their local Veterans Administration, or some other reference. With regard to quality measures, he said he sees a disconnect between those who write the measures and those who actually know what information is collected at a visit. They should move from chart abstraction mode, maybe by working from the bottom up.

Neal Calman agreed that the 10% out of network requirement piece is problematic. Why let meaningful use drive the relationships that providers have for patient care, rather than following the relationships that they actually have? The more integrated systems become—which is really the federal calling—the harder it will be to find people outside those systems. T hat signal is going to be misread by a lot of people. Additionally, Calman sees this as a certification requirement, not a meaningful use requirement.

5. Update on CMS' Meaningful Use Activities

Anthony offered a brief presentation on January's meaningful use activity statistics, with a glimpse at February's, although those numbers were not yet finalized. He discussed active registrations for Medicare and Medicaid EHR Incentive Programs. Forty-two states are active, and in February $30 million was paid out in Medicare and Medicaid incentives, making it the biggest month so far. He shared some highlights related to thresholds and popular and unpopular menu objectives.

Anthony also showed a graph of performance in various categories by state, though he said he is not sure there is enough of a critical mass to explain the reasons for these performance statistics. With $3.8 billion dollars paid out to date, he said they are pleased with the progress.

The meeting broke for lunch. When the Committee reconvened, Tang asked for approval of the minutes from the February 1, 2012, HITPC meeting.

> **Action Item #1:** Minutes from the February 1, 2012, HITPC meeting were approved by consensus.

6. Briefing on Survey of Consumer Attitudes Towards EHRs

Christine Bechtel discussed an online survey that was conducted last August by the National Partnership for Women & Families. The survey was also offered in Spanish, given that the Hispanic population is the fastest growing segment of the U.S. population. They asked respondents how useful they think EHRs are, or how useful they would be when it comes to a number of different categories. The Hispanic segment of respondents were significant percentage points higher in saying the EHR helped them personally in a variety of categories.

The survey found that online access increases perceptions of value and trust. Functionality is important: if online access does not allow communication with the doctor, or does not provide complete access, or if the records are full of errors that need correcting, then people will not utilize online access.

Hispanic respondents were 15% more likely to indicate that online access gives them incentive to do something about their health. Two-thirds of the respondents reported that they want online access, and that number was even higher for Hispanic respondents. Both groups of respondents rated EHRs higher than paper systems in complying with patients' rights and enhancing elements of privacy. That said, a large percentage are worried that more EHRs will mean more breaches. Respondents whose doctors use paper records were about 10% higher response rates indicating these types of concerns.

There is a clear relationship between the value people experience from a record system and their trust in that system. The survey also showed that consumers do not fully grasp what is possible with privacy protection functions.

Discussion

One participant asked whether work has been done to examine how the perception of EHR privacy tracks with broader consumer tools like Facebook and Google. Those sites have a "take it or leave it" approach when asking for consumer data. Bechtel said that they did not specifically make that link, but there were some data points about whether they experienced data breach and the like. Two percent had experienced problems, but 80% were worried about it. She thinks there is a big connection between what people read in the news and what they are worried about.

Joe Francis asked whether they have plans to address public attitudes towards the downstream use of de-identified data for research purposes. Bechtel said that they hope to add questions about that in the future. Deven McGraw said that she just looked into that in her research—in one survey, people did differentiate between identified and de-identified data, but in another survey, most people were quite comfortable with their de-identified information being used for research. Bechtel said that this points to the need for a better-vetted set of questions. Francis said that in a veterans panel, when these concepts are explained, views become more positive. The ideas are sufficiently abstract that significant information must be given to respondents. Paul Tang expressed hope that the National eHealth Initiative will help to explain how EHRs can benefit the consumer directly.

7. Update on Health Information Exchange

Claudia Williams, Director of the State HIE Program at the ONC, explained that elements of her office's activities can be found in the work that this Committee is doing focused on governance and meaningful use. She referenced a paper that was released on March 5th in *Health Affairs* on HIE strategy. A major complaint point for patients, vendors, and the whole system is care coordination, which is done today with little exchange. Survey data shows that 73% of the time, patients do not get discharge information within 72 hours, and only 19% of hospitals report that they are sharing clinical information electronically. The cost of exchange is high, and it requires a significant amount of time to develop.

That said, new payment models and approaches are rapidly developing, which create a business case for exchange. More than 70% of hospitals plan to invest in health information exchange (HIE) services, and the number of active "private" HIE entities tripled from 2009 to 2010.

When people are looking at new payment models, Williams said, it's patently obvious that they need to be investing in technologies. Related to that, they are seeing a prolific Google+ debate around a piece that Les Leonard wrote about models for health insurance exchange. He posted an architecture that he feels that the ONC should be advancing, and the conversation rotated to real-life information about models and approaches for exchange.

Williams explained that today's situation is unacceptable for these reasons:

- Patients should not have to worry about whether their health information can be securely transferred to their point of care when they need it most.
- Clinicians should not have to worry about whether they are going to be able to securely access a patient's health information when care decisions need to be made.
- Health systems should not have to worry about whether they will lose business if they share patient information with their competitors.
- Vendors should not have to worry about whether their systems can talk to each other.

ONC's job is not to build a network or designate a single architecture, or to pay for exchange for everybody. Rather, it is to reduce the cost and the complication of exchange, and to increase trust and reduce perceived risk. The government must define the target and enable scalable exchange to occur. They are taking modular building block approaches to this challenge, attacking on multiple fronts. Williams explained that stage 1 got the ball rolling, with vocabularies, code sets, and content structure standards. Next, a common approach to transport is needed, as are more highly specified standards to support care transitions and lab results delivery. Exchange on a national scale requires some additional layers, and this year they are addressing components for scalable exchange, including directories, certificate management and discovery, and governance.

Regarding query-based exchange, Williams said that fabulous work is being done in the Nationwide Health Information Network Exchange. But some of the standards are not as usable as people would like. With consumer-mediated exchange, there is not a lot of use right now, although some components in meaningful use will drive that forward. It would be exciting to develop a scalable way to accomplish that across vendors. To that end, five states are convening later this month to initiate consumer data sharing over the next 6 months. Williams discussed a variety of future challenges, and opened the floor for discussion.

Discussion

Joe Francis asked if they know, after a clinical encounter, about the natures and types of downstream encounters with other providers. It's one thing to base meaningful use on direct transfers, but he wonders about often the patient shows up somewhere else, without the upstream provider being aware of it. That shows the extent of the problem that they are trying to solve. It is almost impossible to anticipate all those connections. Mostashari concurred that they need the full portfolio of connections. Many of the building blocks will be reused and reusable, with the federal partners and others getting to the point where they can have not just proactive and planned care, and not just a consumer-centered ability to gather information, but actually the ability to query and pull. Maybe initially this will be only with the conscious and clothed patient, but later even with emergency room patients.

A speaker said that accountable care organizations (ACOs) are talking about shared care plans. What is needed is not just transactional, but at least some parts of the medical record that are truly shared. In the standards work that has been done, one of the biggest difficulties is that there is no clarity around the clinical processes, the legal framework, privacy access, who owns the care plan, who can change it, whether it is health-plan centered or patient-centered or centered around a group of providers or a social services agency, etc. Before they get to technology enabling, more work is needed on models with clinical and workflow concepts.

In response to a comment by Paul Egerman, Mostashari said they are looking for an existing source of information on monthly transaction volumes and other benchmarks to measure how the industry is doing with regard to exchange. Should they be asking the EHR vendors if they would voluntarily provide monthly transaction volumes?

Neil Calman discussed an effort in New York to roll out Health Home, which involves integration among health, housing, mental health, and other agencies. Each county is developing its own committee to figure out how to share information. The longer they go, the more deeply invested people will be in their local solutions. He asked, what is the vision of what will happen at the end of this game? Mostashari explained that the vision of the future is one a one-size-fits-all method. There will be many different ways to share information. There are some common building blocks around standards, directories, and trust. He wishes he could say, "here's the vision of the future, New York. Go build this." But the country does not have that type of system, and the risks of that approach are high. It would not be prudent as a national strategy. They must have a lot of different irons in the fire that enable a whole host of approaches.

Calman emphasized that Mostashari's comments are a message that is important to disseminate. It adds credibility to the work that everybody is doing now. It's not just to say that whatever people are working on locally is temporary until the "big thing" happens, but rather that the things people are working on will be the solution.

Larry Wolf suggested that there is something basically broken in the "push" model, and not just in health care. He has heard doctors say, "don't send me lab results." But when the doctor opens the patient chart, that's when he want to see the lab results. There is a pull element even in this push. Wolf suggests that every time they advocate for push, they should look at the pull piece. They can flip the trust issues if they look at pull.

Another Committee member pointed out that in other areas of life, sometimes people pick up the phone, sometimes they send an e-mail, sometimes they use Facebook, and sometimes they even write a letter. It's not an evolution; it's that people pick the right tool and approach for the situation. They should expect that with health care communication—there will be that same kind of heterogeneity across the board. They must structure meaning, in value sets, codes, and vocabularies, and standardize the structure of the information and the foundational security.

8. Public Comment

Tom Bizarro, First Databank, noted that many years ago pharmacists saw that the use of a computer was of great value. When he started in pharmacy, a patient record was on a card in a shoebox. Now, there are sophisticated pharmacy management systems. In the complex world of total health care, if standards, registries, repositories, etc. are defined, then pharmacies will figure out how to exchange that data, and business and partnership agreements will evolve to indicate what is needed.

Chantal Worzala of the American Hospital Association appreciated the conversation around new ways to think about quality measures derived from the information collected during the course of care. Medicare is moving quickly to performance-based payment models, so it is important to have models that are reliable, accurate, and feasible to calculate. T hey are not there yet. She suggested taking a step back from the number of measures to calculate and systematically evaluate the experiences of stage 1. In the information included with the proposed rule, it states that in the first year of meaningful use, just 4% of physicians and 8% of hospitals successfully implemented. In stage 2 they are talking about penalties. The notion of a 2-year look-back for assessing penalties just shortens the runway for people to get on the escalators. CMS expects the majority of physicians to face cuts in the Medicare program through meaningful use. From a policy perspective, they should look at how those cuts will likely affect care. Also, she acknowledged the large amount of ongoing work associated with promoting exchange, but pointed out that per today's presentation, 93% of hospitals deferred the summary of care record. This is not due to a lack of interest, but because they do not have a way to conduct the exchange. Stage 2 ups the ante considerably. Much work is needed to determine why it did not work in stage 1 and how that information can be used to support stage 2.

Carol Bickford, American Nurses Association, appreciated the CMS update on the NPRM, and asked if the slides would be posted to the Web site. She also thanked the National Partnership for Women & Families as looks forward to digging into those results and pledges to help put the "I" in HIT.

Robin Raiford from the Advisory Board told the group about the Whiteboard Story Poster, a comparison of meaningful use stage and proposed stage 2 rules. She will send it to Mary Jo Deering, but it can be found by doing an Internet search for "Meaningful Use Whiteboard."

Before adjourning the meeting, Paul Tang thanked Committee and indicated that the next meeting will include a briefing on the Meaningful Use Workgroup's draft response to the NPRM.

SUMMARY OF ACTION ITEMS:

Action Item #1: Minutes from the February 1, 2012, HITPC meeting were approved by consensus.